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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

CITY OF AKRON, *et al.*,
Petitioners,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *et al.*,
Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *et al.*,
Petitioners,

v.

CITY OF AKRON, *et al.*,
Respondents.

ON A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF *AMICUS CURIAE* OF THE NATIONAL ABORTION FEDERATION

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INTEREST OF AMICUS

This brief is filed in support of the Akron Center For Reproductive Health, Inc., et al. by the National Abortion Federation (hereinafter NAF), a not-for-profit professional organization dedicated to preserving the right of all women to choose a safe legal abortion.[1/] NAF has more than 230 abortion clinic members in 41 states, the District of Columbia and Puerto Rico, including the Akron Center for Reproductive Health, the lead plaintiff in this case. NAF members also include physicians who provide abortion services in their offices

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1/ Counsel for the parties to this appeal have given their consent to the filing of this brief. Their letters of consent are filed with this Court.

as well as other organizations and individuals committed to the preservation and provision of safe legal abortions.

Founded in 1977 to fill the need for a national professional forum for abortion service providers, NAF provides a panoply of programs and services designed to guarantee high quality patient care and ensure access to safe and inexpensive abortion services.

NAF has promulgated exhaustive standards, formulated by special committees of practitioners and experts, on the medical, nursing, counseling, administrative and ethical aspects of abortion services. NAF standards are designed and implemented to promote the health, safety and psychological well-being of patients. They

are reviewed regularly and updated to reflect the most advanced knowledge in the field. NAF's current standards are set forth in full as an appendix hereto. Whenever possible, NAF works closely with health departments and legislative bodies in order to promote awareness of and conformity with these standards for quality care.

NAF periodically assesses the need and trends in the profession and provides several forums for the presentation of new information based on technological advancement, research and experience. NAF offers post-graduate medical seminars, accredited by the American Medical Association for continuing education credits, which concern the prevention and management

of complications of abortion. NAF also sponsors regional workshops in the areas of nursing, counseling, public affairs, and management.

NAF is a clearing-house of information to abortion service professionals and the general public on all aspects of abortion services. NAF distributes information on both the availability and cost of a variety of reproductive health services in addition to abortion, including fertility counseling, pre-natal care, home birthing, contraception and male and female sterilization. NAF also collects and disseminates information about violence against abortion providers and women seeking abortion in an effort to assist them in preventing violent attacks and managing them when they do

occur.

NAF undertakes specific research and publishes reports as part of its public education program. A special NAF task force recently published a report entitled Minors and Abortions, a copy of which has been lodged with the court. NAF also offers an information brochure, in English and Spanish, about abortion as well as printed guidelines on how to choose an abortion facility.

NAF has established the only national toll-free Hotline offering the general public and women seeking abortion information on a wide variety of subjects relating to abortion and reproductive health. NAF encourages feedback from Hotline consumers, and promptly investigates complaints about abortion providers.

More than 10,000 women and men -- teenagers, parents, husbands, social workers, teachers, ministers and even judges -- have used the Hotline service.

NAF does not promote the choice of abortion; rather it seeks to ensure that the means of effectuating that choice are both safe and accessible. NAF's Public Policy Action Program is designed to ensure continued access to safe legal abortion by educating the professional community and the thousands of men and women who daily visit NAF clinics across the country to meet the increasing threats to legal abortion.

NAF members provide approximately half of all the abortions in the United States. NAF constantly strives to assure that its members and the entire medical community have the tools and information

to provide the highest quality care to abortion patients. Thus, NAF opposes governmental attempts to interfere with and hamper the provision of quality medical and psychological care to abortion patients.

SUMMARY OF ARGUMENT

The Constitution guarantees that the fundamental right of privacy which includes the right to choose abortion cannot be eviscerated by anti-abortion factions in local legislatures. No law which directly interferes with a woman's access to abortion can withstand rigorous Constitutional scrutiny unless it is narrowly tailored to meet a compelling state interest.

Akron has enacted an explicitly anti-abortion and thoroughly unconstitutional

Ordinance, broadly drawn for the purpose of discouraging abortion and inhibiting access to abortion services.

The requirement that physicians personally counsel abortion patients prevents women from obtaining the benefit of medical judgment that trained counselors are best qualified to obtain truly informed consent and ensure that a woman's choice to terminate a pregnancy is uncoerced.

The parental consent requirement fails utterly to permit mature minors to make the abortion choice for themselves or to allow immature minors to avoid parental involvement when it is not in their best interests.

The restriction of second trimester abortions to hospitals fails to serve a

compelling state interest in women's health. Outpatient abortions even during the second trimester are now as safe as childbirth and in-hospital abortions. By restricting second-trimester abortions to hospitals when Akron hospitals fall woefully short of meeting the need for the service, Akron not only fails to promote women's health, it actually harms the health and well-being of women.

ARGUMENT

POINT I

LEGISLATION THAT INTERFERES WITH THE EFFECTUATION OF THE FUNDAMENTAL RIGHT TO CHOOSE ABORTION IS UNCONSTITUTIONAL UNLESS NARROWLY TAILORED TO MEET A COMPELLING STATE INTEREST

This Court has long recognized that the Constitution guarantees a fundamental right of privacy in matters of reproductive choice. Griswold v. Connecticut, 381 U.S. 479 (1965); Cf. Skinner v. Oklahoma, 316 U.S. 535 (1942)(the right to procreate is a fundamental constitutional right). In Roe v. Wade, this Court established that the "right of privacy . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." 410 U.S. 113,

153 (1973). Because the right of privacy guarantees independence in making certain fundamental decisions about whether or not to bear a child, state regulations interfering with the effectuation of these decisions "may be justified only by a 'compelling state interest' . . . and . . . must be narrowly drawn to express only" that interest. Id. at 155. Laws that limit access "to the means of effectuating" decisions in matters of childbearing receive the same rigorous scrutiny as laws that prohibit choice altogether, since "access is essential to exercise of the constitutionally protected right." Carey v. Population Services International, 431 U.S. 678, 688 (1977).

The Constitution ensures that women's right to effectuate the abortion decision may not be eroded by state interference with the provision of abortion services. This Court has the power and the duty to invalidate state and federal statutes in conflict with the Constitution. Martin v. Hunter's Lessee, 14 U.S. (1 Wheat) 304 (1806), Marbury v. Madison, 5 U.S. (1 Cranch) 137 (1803).

When political turmoil threatens the enjoyment of fundamental constitutional rights, this Court must be especially vigilant to protect

> individual freedom of mind in preference to officially disciplined uniformity for which history indicates a disappointing and disastrous end.

West Virginia Board of Education v.

Barnette, 319 U.S. 624, 637 (1943); see also, Cooper v. Aaron, 358 U.S. 7, 18-19 (1958); Brown v. Board of Education, 349 U.S. 294, 299-301 (1955).

Mr. Justice Jackson, writing for the Court in Barnette, illuminates the vital necessity of protecting fundamental rights from erosion or extinction through the political process:

> The very purpose of a Bill of Rights was to withdraw certain subjects from the vicissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by the courts. ...[F]undamental rights may not be submitted to vote; they depend on the outcome of no elections.
>
> Nor does our duty to apply the Bill of Rights to assertions of official authority

depend upon our possession of marked competence in the field where the invasion of rights occurs. True, the task of translating the majestic generalities of the Bill of Rights, conceived as part of the pattern of liberal government in the eighteenth century, into concrete restraints on officials dealing with the problems of the twentieth century, is one to disturb self-confidence.

* * *

But we act in these matters not by authority of our competence but by force of our commissions. We cannot, because of modest estimates of our competence . . . withhold the judgment that history authenticates as the function of this Court when liberty is infringed.

319 U.S. at 638-40.

A. Regulations That Inhibit Access to Abortion Services Must be Subjected to Rigorous Judicial Scrutiny

This Court has consistently applied the strict test enunciated in Roe v. Wade to state regulations that directly interfere with the right to choose abortion. Statutory provisions that create obstacles for a woman seeking abortion services burden her right to have an abortion. Unless such legislation is narrowly drawn to serve a compelling state interest, it is unduly burdensome and unconstitutional. Doe v. Bolton, 410 U.S. 179 (1973); Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976). Colautti v. Franklin, 439 U.S. 379 (1979). See also Bigelow v. Virginia, 421 U.S. 809 (1975).

Only those regulations imposing no "legally significant" obstacle to the effectuation of the abortion decision need not be subject to rigorous review. For example, Danforth upheld a requirement for written informed consent and certain reporting requirements because this Court found that neither provision presented any obstacle to a woman's ability to effectuate her decision to have an abortion. 428 U.S. at 66-68, 80-81. However, this Court explicitly cautioned states against informed consent and reporting provisions that burden the abortion decision and its effectuation. Id.

This Court has also upheld restrictions on government funding of abortions on the ground that refusal to subsidize abortions simply is not a state created obstacle to the effectuation of the

fundamental right to choose abortion. Harris v. McRae, 448 U.S. 297 (1980); Maher v. Roe, 432 U.S. 464 (1977). Finding that there was no fundamental right to Medicaid payments for abortions, this Court subjected the restrictions only to minimal review. Id. Neither Maher nor McRae affects the rigorous review required here. In both cases, this Court specifically distinguished funding restrictions from "direct state interference with a protected activity," and reiterated that rigorous review is appropriate where, as here, "the State attempts to impose its view by force of law...." Maher, 432 U.S. at 475-76; McRae, 448 U.S. at ____, 101 S.Ct. 2671, 2686-88.

This Court's decisions concerning minors' rights to abortion similarly do not dilute the heightened standard of

review applicable to direct state interference with all women's access to abortion. The cases holding that a minor's access to abortion is not coextensive with an adult's are grounded on special considerations applicable only to minors because of their youth. H.L. v. Matheson, 450 U.S. 398 (1981); Bellotti v. Baird (II) 443 U.S. 622 (1979); Bellotti v. Baird (I) 428 U.S. 132 (1976).

B. Regulations That Hamper The Exercise of Medical Judgment Burden a Woman's Right to Choose Abortion

Laws that encumber the physician's exercise of medical judgment in providing abortion services are as unconstitutional as statutes which directly obstruct a woman's access to those services. Doe v. Bolton, 410 U.S. 179 (1973). Although

recognizing the "presence of rascals in the medical profession as in all others", this Court has held impermissible legislation that cramps medical judgment because such legislation inevitably impinges on a woman's right to receive abortion services "in accordance with her licensed physician's best judgment." Id. at 197. See also, Whalen v. Roe, 429 U.S. 589, 604 n. 33 (1977).

This Court has consistently "underscored the importance of affording the physician adequate discretion in the exercise of ... medical judgment." Colautti v. Franklin, 439 U.S. 379, 387 (1979), citing Doe v. Bolton. See also, United States v. Vuitch, 402 U.S. 62 (1971).

Licensed physicians throughout the country have, over the last decade,

relied increasingly on freestanding abortion clinics to provide abortion services. The vast majority of abortions in this country are performed in freestanding clinics. Henshaw, et al., "Abortion Services in the United States, 1979 and 1980," 14 Family Planning Perspectives No. 1, p. 5 (1982). Clinics not only provide high quality comprehensive medical care to abortion patients but assure the greatest access to abortion services at the lowest possible cost. Id. at 11. The health care team in abortion clinics, led by the physician, includes nurses, nurse practitioners and counselors or health advocates.

Abortion clinics not only best serve the needs of abortion patients but have provided a model for the delivery of outpatient surgical care in general. Only

recently have other surgical services become available on an outpatient basis. See, for example, Foster, "Ambulatory Gynecologic Surgery," "Ambulatory Care In Obstetrics and Gynecology, Ryan, G. Ed. (1980).

The physicians responsible for providing abortions have chosen to provide the services in freestanding clinics. States may not burden access to abortion services simply because clinics do not provide services in the traditional doctor-patient mode. Legislation that has the purpose and effect of discouraging the abortion choice and, if the choice is nonetheless made, of making abortion services more expensive and less accessible, directly interferes with access to abortion and inevitably has an adverse impact

on women's health and well-being. Such legislation impermissibly "limits" the right of women seeking abortion "to receive medical care in accordance with her licensed physician's best judgment." Doe v. Bolton, 410 U.S. at 197.

POINT II

SPECIFIC PROVISIONS OF THE AKRON ORDINANCE CANNOT WITHSTAND RIGOROUS JUDICIAL SCRUTINY

The provisions of the Akron Ordinance presented for review here deliberately interfere with women's ability to effectuate their right to choose abortion. The law is not narrowly tailored to meet any compelling state interest. To the contrary, it is broadly drawn to discourage abortion and inhibit access to abortion.

A. The Counseling Requirement Forces Patients To Receive Incorrect and Alarming Information Only From Physicians

Section 1870.06 of the Akron Ordinance forces physicians to recite to women seeking an abortion an anti-abortion litany of largely irrelevent and inaccurate "information." Requiring attending physicians to personally counsel their abortion patients impermissibly interferes with the exercise of their medical judgment, and their patients right to medical care in accordance with that judgment.[2/]

2/ Amicus does not address in detail the patently unconstitutional substantive information requirements amply briefed by plaintiffs and other amici. Indeed, the City of Akron virtually concedes the unconstitutionality of these requirements, arguing instead that they should be severable.

Physicians have recognized that the traditional doctor-patient dialogue is not the only or even the best way to ensure that a patient gives informed consent to surgery. Many doctors have rejected the traditional model in favor of comprehensive counseling services provided by trained counselors. Abortion counseling is designed not only to provide patients with information concerning the abortion procedure but also to ensure that their choice to have an abortion has been freely made without coercion. See NAF Counseling Standards at A-8 through A-13.

Counseling by specially trained counselors is a particularly innovative practice in the delivery of abortion services. There is no other medical setting that offers such an opportunity

for educational and emotional guidance from specially trained non-physician staff. Because they are not physicians, counselors are less intimidating to patients who are more willing to talk openly to counselors. Counselors are less inclined than doctors to use abstruse and technical language so patients understand counselors more easily.

This Court has warned that states may not use informed consent requirements to "confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession." Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 67 n. 8 (1976). By forcing physicians to personally counsel their abortion patients, Akron impermissibly restrains physicians and denies their abortion patients the right

to counseling services in accordance with their doctors' best medical judgment.[3/]

B. The Parental Consent Requirement Unconstitutionally Fails To Permit Mature Minors To Consent To Abortion Or Allow Immature Minors Whose Best Interests Are Not Served by Parental Involvement To Obtain Abortions Without Their Parents' Knowledge

This Court has repeatedly recognized how devastating unwanted pregnancy can be for teenagers. Michael M. v. Sonoma County, 450 U.S. 464 (1981), Bellotti v. Baird, 443 U.S. 622 (1979).

Accordingly, although recognizing an important state interest in encouraging

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3/ Akron's efforts to restrict medical judgment as to appropriate counseling services would likely have the no doubt intended side effects of reducing the availability and driving up the cost of abortion services. Physicians forced to spend time in extensive counseling sessions will be able to perform abortions for fewer patients. These patients able to receive services will inevitably have to bear an increased cost.

pregnant minors to consult their parents, this Court struck down a statutory scheme which even provided a judicial alternative to parental consent because the law failed to provide a complete by-pass to parental involvement in the abortion decisions of mature minors and those immature minors whose best interests would not be served by parental involvement. Bellotti v. Baird, 443 U.S. 622 (1979). See also H. L. v. Matheson, 450 U.S. 398 (1981), (Powell, J., concurring).

Like the Massachusetts Law held unconstitutional in Bellotti (II), the Akron Ordinance fails to account for the right of mature minors to make the abortion decision for themselves or to protect even the immature minor for whom parental involvement would be harmful.

The law also fails to provide a quick and confidential procedure to secure judicial authorization for an abortion.

NAF endorses encouraging young pregnant women to involve their parents in their decision whenever possible and recognizes that "[i]n most cases, parents are supportive of their daughters in time of crisis and decision." NAF, Minors and Abortion at 24. However, in those cases where parental involvement would be harmful, it is crucial that the young pregnant woman be permitted to obtain an abortion without her parents' knowledge and be able to secure that permission without delay.

Minors are, for a variety of reasons, more likely to delay seeking the abortion than older women. Minors

and Abortion at 13. Minors, because of their youth, are less likely to recognize signs of pregnancy, less sophisticated about access to health care, less likely to have ready financial resources, and more frightened of revealing their plight. Id. If their own delay is exacerbated by state created delays in securing judicial authorization, the risk to their health is staggering. Id.

The Akron Ordinance fails utterly to account for mature minors or to protect the immature whose best interests would not be served by parental involvement. The law does not, as the Constitution requires, meet the needs of young women coping with unwanted pregnancy.

C. Restricting Second Trimester Abortions Unconstitutionally Restricts Access To Abortion and Fails To Protect Women's Health

Akron's restriction of second trimester abortion procedures to hospitals not only directly interferes with effectuation of the abortion decision, it precludes the second trimester abortions for many women because Akron hospitals do not begin to meet the need for the service. See Akron Center For Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, 1209 (6th Cir. 1981). Moreover, it substantially increases the cost of the service to those few women who will be able to obtain second trimester abortions in Akron. Id.[4/]

4/ The Sixth Circuit held that although the second trimester restriction unduly burdened access to abortion, it was bound by Gary-Northwest Indiana Women's Service, Inc. v. Orr, 451 U.S. 934 (1981), aff'g

(Fn. continued next page)

(Fn. continued from preceding page)
496 F. Supp. 894 (N.D. Ind. 1980) to uphold the provision. 651 F.2d at 1210. In Gary-Northwest, this Court summarily affirmed the refusal of a three-judge court to vacate its earlier judgment and enjoin an Indiana statute restricting second trimester abortions to hospitals.

Summary affirmances reject only the specific challenges presented in the jurisdictional statement. Mandel v. Bradley, 432 U.S. 173, 176 (1977), Fusari v. Steinberg, 419 U.S. 379, 391-393 (1975). (Burger, C.J. concurring). The questions presented in Gary-Northwest went to procedural issues not relevant here. The only arguably substantive issue presented in Gary-Northwest was "whether the lower court had abused its discretion in failing to issue a preliminary injunction." No. 80-1275, Jr. St. at i (emphasis added). "In reviewing...interlocutory relief, this Court ...intimate(s) no view as to the ultimate merits..." Brown v. Chote, 411 U.S. 452, 457 (1973).

Unlike the Indiana statute at issue in Gary-Northwest, Akron's second trimester restriction was fully litigated at a trial on the merits. Moreover, the Indiana statute, in sharp contrast to this one, defined hospitals to include ambulatory outpatient surgical centers.

Thus, the summary affirmance in Gary-Northwest is not precedent here.

In Roe v. Wade this Court, on the basis of evidence of the relative safety of abortion and childbirth then available, held that, because second trimester abortions were then less safe than childbirth,

> ...the state's important and legitimate interest in the health of the mother [becomes] "compelling..., in light of present medical knowledge,..." at approximately the end of the first trimester.

410 U.S. at 163 (emphasis added). Roe accordingly held that states could regulate abortions in the second trimester, but only to further "the preservation and protection of maternal health." Id.

In Danforth, this Court, utilizing the strict scrutiny applicable to all laws impinging on fundamental rights, struck down a Missouri statute banning saline infusion procedures in the second trimester because

it had the effect of virtually eliminating access to second trimester abortions and was not narrowly tailored to preserve women's health. 428 U.S. at 79.

Application of the rigorous scrutiny mandated by Danforth to the hospital restriction here requires its invalidation notwithstanding the suggestion in Roe v. Wade that restricting second trimester abortions to hospitals or specially licensed clinics might be constitutional. 410 U.S. at 163. There, this Court relied heavily on the policy of the American Public Health Association ("APHA") recommending a hospital setting for second trimester abortions which was based on the risks associated with the technology available at that time. Id. at 144-146, 163.

Since Roe v. Wade was decided, technological advances in the provision of second trimester abortions, pioneered by NAF members, have resulted in the availability of safe second trimester abortions on an outpatient basis. For example, Dilation and Evacuation (D&E) abortions, which were virtually unknown in 1973, are available on an outpatient basis during the second trimester and safer than childbirth. The APHA has accordingly changed its policy to recommend outpatient second trimester services, and, like NAF, is urging this Court to strike down Akron's second trimester hospital restriction. See, brief Amicus Curiae of APHA. The briefs of the American College of Obstetrics and Gynecology and the American Medial Association and of the Planned Parenthood Federation of America, among others, also docu-

ment the safety of outpatient second trimester abortions and support the position urged here.[5/]

Like the saline ban in Danforth, Akron's hospital restriction cannot withstand rigorous scrutiny and

> ...fails as a reasonable regulation for the protection of maternal health. It comes into focus, instead, as an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vast majority of abortions after he first 12 weeks.

428 U.S. at 79.

5/ The technological strides made since Roe suggest that the state's interest in maternal health may not become compelling and justify any regulatory obstacle until the end of the second trimester of pregnancy. See Margaret S. v. Edwards, 488 F. Supp. 181, 194-196 (E.D. La. 1980).

CONCLUSION

For the reasons stated above this Court should hold unconstitutional all of the Akron ordinance provisions restricting access to abortion services.

Respectfuly submitted,

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NATIONAL ABORTION FEDERATION

STANDARDS

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FOREWORD

While the National Abortion Federation is an organization specifically committed to questions of the provision of quality abortion services for women, it recognizes that education about abortion procedures and services should be the responsibility of all health agencies and professionals concerned with the care of women. Health professionals in every state should accept this educational responsibility. These agencies and individuals should assume a leadership role in making essential facts known to the public, other health professionals and non-professionals who have contact with individuals in need, and members of all branches of government who must make

informed decisions about the role of abortion in our society. The facts are:

* Women should be as free as possible in their personal choice involving abortion and should not be coerced in any way.

* Individuals contemplating abortion should be encouraged to seek information and counseling from the best available source.

* Educational literature on abortion should be easily obtainable. Such literature should indicate the means by which individuals obtain information and services, describe the current legal status of abortion, discourage individuals from seeking a dangerous illegal abortion, emphasize the availability of contraception as a means of avoiding unwanted pregnancy, make

available information regarding Medicaid, other insurance coverage, and other sources of funds for those in need; and supply information on the availability of contraception and male or female sterilization.

* Both risks and costs are less when abortion is sought early in pregnancy.

* The symptoms of pregnancy should be widely known so that those wishing to terminate an unwanted pregnancy may seek assistance at the earliest stage of pregnancy. Since the risks of complications are lowest in early pregnancy, the early detection of pregnancy and determination of appropriate management should be encouraged.

* The diagnosis of pregnancy should be confirmed prior to abortion through the

performance of adequate physical examination and reliable laboratory tests for pregnancy.

* If travel to another community for an abortion is contemplated, patients should confirm the actual presence and stage of pregnancy before travel plans are made.

* Abortion should be legally performed by or under the supervision of licensed physicians who have been adequately trained to prevent, recognize, and treat the complications which may ensue.

* Adequate followup care, which includes the identification and knowledge of specific contacts for post-procedure medical services, is essential to the prevention and detection of post-abortion complications.

PREAMBLE

Abortion is a health service and should be provided to the public with the same attention to standards of safety, effectiveness, and regard for patient rights as other health services. Abortion services are an integral part of comprehensive family planning and maternal and child care.

The availability of safe abortion services to all who need them is essential to community health, personal freedom, and individual dignity. The National Abortion Federation is committed to the provision of these services under humane circumstances whenever and wherever they are offered.

In order to insure that these purposes are fulfilled, we believe that standards in abortion services should be

followed in the areas of counseling, nursing, medical and surgical procedures, informed consent, followup care, ethics, administration, reporting and referral.

The rigorous maintenance of high standards of care does not preclude the development of new techniques and innovative methods of service delivery that achieve quality care.

Where a facility departs from a stated NAF standard, the facility is expected to provide full documentation of the alternative they have chosen and demonstrate its effectiveness in fulfilling the intent of the standard in question.

All underlined sections in this document are obligatory standards for NAF member facilities and must be current practice for membership in good standing.

All other sections are advisory and strongly recommended.

COUNSELING STANDARDS

Philosophy of Counseling

Decision counseling seeks no pre-determined outcome, but encourages exploration of all possible alternatives, the final choice resting entirely with the woman. By establishing a relationship based on empathetic understanding and non-judgmental support, the counselor attempts to assist women as necessary with decision making, anxiety reduction, and informed consent. The woman's autonomy and control should be supported to the fullest. The counseling contract should be agreed upon by the woman and the counselor at the beginning and should clearly identify the counseling objectives. These should be distinguished from other issues and objectives such as the provision of

information.

It should be assumed, unless evidence is otherwise presented, that the woman is mentally competent. Like other major life decisions, decisions around pregnancy may involve confusion, ambivalent feelings, and value conflicts which make counseling an important part of the service provided. However, it does not mean necessarily that the woman is sick or helpless. Counseling should be offered but not imposed, and it should not constitute a barrier to appropriate service. Counseling should always be consistent with the needs of the woman.

Objectives of Counseling

The following objectives must be fulfilled in response to the need of the individual woman and should be accomplished on an individual basis in

privacy. The opportunity for individual counseling must be offered to every woman:

* to assist the pregnant woman, as needed, in exploring her feelings about her pregnancy, her circumstances, and her options;

* to assist the woman, as needed, in decision-making by helping her face the task of choosing, encouraging a careful examination of all options, providing accurate information, and supporting her right to choose for herself, free of all coercion so that she retains her sense of autonomy and control;

* to refer, when appropriate, for implementation of the woman's choice or for further counseling or additional medical services.

The following objectives must be

fulfilled with every woman who chooses abortion and may be accomplished either on an individual basis or in group sessions, providing that attendance at a group session is voluntary:

* to insure informed consent by establishing that the patient is mentally competent and appears to understand the nature and consequences of the procedure;

* to prepare the woman for surgery in a manner that facilitates her safety and comfort;

* to offer the woman an opportunity to understand her fertility, to assist her in reaching a decision about the method of contraception she will use, if any, and respecting her choice.

Qualifications of Counselors

The counselor should be an empathetic, responsive, caring person who

understands how to discipline herself in order to be helpful to others.

She should be comfortable with her own sexuality and nonjudgmental in her attitude toward the sexuality of others.

She should understand how to help a woman make health care decisions and be able to distinguish those decisions from moral and medical judgments, which have no place in the counseling session.

She should understand and observe a professional code of ethics.

She should be receptive to supervision and to training in counseling skills and family planning practices.

Training and Supervision

Counselors must be provided initial training that covers at least the following topics in detail:

* sexual and reproductive health

* abortion technology
* contraceptive technology
* short-term counseling skills
* community resources and referrals
* informed consent
* agency policies and practices

NURSING CARE STANDARDS

Objectives

The objectives of abortion nursing services include:

* the use of the nursing process to assist each patient in reaching her highest level of emotional and physical well-being before, during, and after her abortion;

* the provision of each patient with basic knowledge about her health so that she may make informed choices regarding her own health care;

* the provision of a safe and health-promoting environment for each patient.

Qualifications of Nursing Staff

The nursing staff includes appropriately trained health workers including but not limited to each

licensed professional, practical, or vocational nurse.

Each staff person providing nursing care must acknowledge and practice within her professional and/or prepratory limits.

Those responsible for nursing care must be skilled in inter- personal communication. These skills include interviewing, crisis intervention, support, and health education. They must exhibit skill in direct patient care, surgical nursing, sterile technique, and the documentation and reporting of these actions.

Each person responsible for nursing functions must understand the basics of reproductive physiology, have a knowledge of contraceptive technology, and have an understanding of the mode of action,

adverse effects and contraindications of medications being dispensed. Each must understand the proper operation and routine maintenance of all medical equipment used. In particular, each must be familiar with the location and proper use of emergency medications and equipment. Knowledge of the emergency protocol and procedure as set forth by the medical director is essential.

Nursing care providers must be sensitive and empathetic to the unique needs of each individual patient and must be committed to maintaining a pro-choice, non-judgmental attitude. They must understand the flow of patients within the facility in order to assure the routine provision of appropriate medical care. They must participate as active members of the health care team.

Those staff members functioning in an expanded nursing role must operate within the limits of written, current and signed medical orders and/or within written protocols and procedures. They must demonstrate an understanding of the implications of their clinical findings, have direct access to medical consultation, and be supervised by a physician licensed in the state in which the practice occurs.

Supervision of Nursing Care

Nursing care must be supervised by a registered nurse or physician. The nursing care supervisor must be capable of directing response in emergency situations, and must participate actively as a member of the health care team. A nurse, physician, or appropriately competent and licensed medical person

must be present in the facility while abortions are being performed and during the time the patients are recovering.

Training of Nursing Staff

Nursing care providers should be provided with a training and orientation period appropriate to the needs and level of preparation of each individual.

The orientation should include information concerning:

* preoperative, operative, and postoperative abortion nursing procedures;

* reproductive anatomy and physiology;

* sexual health;

* current contraceptive technology;

* emergency procedures;

* sterile technique;

* documentation and charting;

* agency policies;

* nursing's role as part of the health care team;

* stress management.

MEDICAL CARE

Quality abortion services should be readily available to all patients who desire these services. Abortion should be an integral part of medical education and of residency training in obstetrics and gynecology and in family practice. Important factors related to the incidence of complications with abortion are the skill and experience of the operating practitioner and the presence of a well-educated supporting staff.

Customary surgical principles dictate the following standards for an abortion faciity:

Pre-operative Care

* An adequate preoperative history and physical examination must be conducted, to include:

an accurate determination of the

duration of gestation;

the identification of any pre-existing conditions or complications; and

the detection of any factors which could influence the choice of procedure, anesthesia, or the pre- and post-operative management.

* Urine testing for pregnancy is essential except when a positive diagnosis of pregnancy has been established by other means such as diagnostic ultrasound. Laboratory procedures to determine hematocrit and Rh factor in every case are mandatory. The desirability of other laboratory procedures will depend upon the population served. These may include sickle cell testing, endocervical and anal culture for gonorrhea, urinalysis, serologic test for syphilis, and when

indicated, cytologic screening for cancer.

Operative Care

* Abortions must be performed only by licensed physicians or by non-physicians who are permitted to do so by applicable law who perform abortions under the supervision of a licensed physician. All personnel performing abortions must have received prior special training in the performance of abortions, and in the prevention, recognition, and treatment of the complications which may ensue.

* All practitioners must work under a Medical Director who is a licensed physician. It is mandatory that the Medical Director or facility have a working arrangement with a physician who has admitting privileges at a local

hospital in order to insure the necessary back- up for medical complications.

* General anesthesia must be given by an anesthesiologist or nurse anesthetist with a physician trained in the treatment of anesthesia complications on the premises.

* Every reasonable effort must be made to evacuate the uterus completely. All tissue must be examined grossly at the time of the abortion procedure by a physician or trained assistant and the results recorded in the chart. In the absence of visible fetal parts or placenta upon gross examination, obtained tissue may be examined under a low power microscope for the detection of villi. If this examination is inconclusive, the tissue should be sent to the nearest suitable pathology laboratory for

microscopic examination. The laboratory discovery of tissue other than that usually associated with uncomplicated intrauterine pregnancy must be reported within 48 hours to the abortion service of operating practitioner for appropriate followup (e.g. trophoblastic disease; suspected ectopic pregnancy). There must be an appropriate mechanism for contacting the patient and informing her of the significance of the report.

Postoperative Care

* The recovery area must be supervised by a licensed nurse or physician who is immediately available to the recovery area. The staff/patient ratio in the recovery area should be appropriate and adequate with regard to the anesthesia used. A physician must be immediately available to the facility as

long as there are patients in the recovery area.

* Prior to discharge, postoperative care should be directed toward confirming that the patient is at minimal risk of serious complications. Periodically, the patient's pulse rate, blood pressure, and external bleeding must be examined for evidence of intra-abdominal bleeding or injury. These observations should be made during the postoperative period, the length of which is partly dependent upon the operative procedure employed. If systemic drugs are used for analgesia/anesthesia, the patient must be fully reactive before discharge.

* The facility must provide continued contact for an availability of postoperative care on a 24-hour basis.

Drugs and Medications

* Drugs, parenteral fluids, and electrolyte solutions must be available in sufficient supply. Physiologic solutions (i.e. normal saline, Ringer's lactate) should be available for use during intravenous infusion of oxytocin. Rh-immune globulin must be explained and administered to Rh-negative patients. Fully informed consent must be obtained from those refusing. Narcotic antagonists must be available when parenteral narcotics are used.

Equipment and Physical Plant

* The facility must have the necessary equipment and gases (including oxygen) for artificial ventilation and for cardiac and pulmonary resuscitation.

* The operating table or conventional gynecologic examining table with accessories must be located in a

room of adequate dimensions, illumination, and ventillation.

* Surgical instruments must be sufficient in number to permit individual sterilization of the instruments used for each procedure and adequate to perform conventional cervical dilatation and curettage. Equipment for vacuum aspiration must be electrically safe and designed to prevent reverse pump action.

* The facility must have the capability to transfer a patient immediately to a hospital operating room for emergency care.

Medical Personnel

* It is the responsibility of the facility to provide for periodic, systematic, and confidential peer review of all practitioners performing abortions and other procedures (e.g. IUD

insertion). This review will include a minimum of:

* observation of operative technique;

* review of complications;

* review of a reasonable random sample of each practitioner's charts;

* review of each practitioner's interaction with patients.

Second Trimester Procedures

All provisions stated above will apply to second trimester procedures, and the following additional standards will be observed:

* Counseling services specifically oriented to the needs of second trimester patients must be available.

* The use of diagnostic ultrasound prior to termination of second trimester pregnancy is highly advisable for

determination of fetal age.

* If a dilatation and evacuation (D&E) procedure is performed under general anesthesia, it is advisable for it to be performed on the premises of a full-service hospital.

* All second trimester procedures performed on an outpatient basis must have immediate access to a full-service hospital within 15-20 minutes door-to-door.

* The procedure must be performed by a licensed physician who has been specifically trained in the performance of this procedure.

* A patient having saline amnioinfusion abortion must be supervised carefully during saline infusion and during oxytocin stimulation to prevent

electrolyte imbalance.

* Fetal expulsion must be planned for occurrence in a medically safe environment such as a hospital or specially equipped clinic facility.

* In amnioinfusion abortion, the patient must be evaluated within two hours after fetal expulsion to determine whether expulsion of the placenta has occurred.

* Nursing services specifically oriented to the needs of second trimester patients must be available for their care.

Emergency Protocol

* Each facility must have a written protocol for emergency evacuation of patients and should conduct regular drills.

* In the evacuation of a patient, medical personnel from the facility should accompany the patient.

* If an ambulance service is not immediately available, the faciity must maintain emergency transportation.

* The Medical Director is responsible for assuring that the patient is properly admitted to the hospital and has competent care from that point.

* All medical staff members must be proficient in cardiopulmonary resuscitation and it is highly advisable that other staff members be proficient in CPR.

* Drugs should be available for the following complications:

cardiac arrest

seizure

asthmatic attack

allergic reaction

narcotic toxicity

hypovolemic shock

* Emergency medications should include:

Narcan R

epinephrine

phenobarbitol injectable USP

Benadryl R

aminophilline

* The following emergency equipment must be available and checked for proper function at regular intervals:

plastic airway

resuscitation bag

cardiac arrest board

defibrillator if general anesthesia is administered

laryngoscope

endotracheal tube

large bore IV catheter needles

IV fluids, tubing and support

oxygen

Determination of Gestational Age

Because the safety of abortion is partly dependent upon the stage of gestation at which it is performed, abortion providers have an obligation to determine gestational age as accurately as possible prior to the choice of procedure. This is particularly important in the later stages of the midtrimester (after approximately 19 weeks LMP).

Policy Statement on Delay of Abortion

The National Abortion Federation recommends that whenever practical, an abortion should be performed within one week of the request to terminate the pregnancy. This includes women who are unable to pay at the time they seek an abortion. It is especially critical that

women not be delayed in having abortions during the 12th through 16th menstrual weeks of gestation.

Should an abortion facility not be able to provide a dilatation and evacuation (D&E) procedure during this interval, it is the facility's obligation to refer women immediately to facilities where such procedures are performed in accordance with NAF standards. Should referral not be possible, women must be informed of the increased risk in delaying until the 17th menstrual week of gestation.

It is the responsibility of abortion facilities, medical schools, and teaching hospitals to train physicians to perform the D&E procedure used during this interval.

Provision for Financial Assistance in

Cases of Complications

An abortion facility should have prior adequate financial arrangements, detailed in a written protocol, to be able to compensate patients who have suffered damages as a result of malpractice. This can include insurance, reserves, or other responsible options.

Public Assistance Funds

In order to fulfill Article II of the NAF Bylaws, members should pursue all possible efforts to be able to receive public assistance funds for both abortion procedures and/or the ancillary services related to abortion and family planning. This includes filing the necessary forms and compliance with state and local regulations for reimbursement.

Fee Schedules

All member facilities mu

prominently display patient fees at reception and cashier offices, indicating services included.

ADMINISTRATIVE PROCEDURES

Personnel Policies and Procedures

NAF member facilities must provide vacation and sick leave benefits for full-time staff members. NAF recommends an annual vacation leave of two weeks (10 days) and sick leave of one day per month (12 days annually). Health insurance coverage is also recommended for employees of NAF member facilities. A written job description including an outline of duties and qualifications should be available for each position. The job descriptions should be updated as duties change.

Performance appraisals should be in writing with the supervisors' and employees' signatures. Performance appraisals should be kept in the employee personnel folder along with other

information pertaining to that employee. The employee has the right to review his/her personnel file upon request. The employee also has the right to an interview by his/her supervisor when requested.

The member facility should provide malpractice coverage to its employees while performing their jobs. Each facility must support Affirmative Action Practices in staffing and advertising positions.

There must be a written and posted protocol for life-threatening medical emergencies. In addition, there must be written descriptions of procedures and policies in each area of care including:

nursing

counseling

abortion procedures

laboratory services.

It is recommended that clinic hours be set considering the needs of the patients as well as the staff.

Clinic Security

Written guidelines must be available for all staff relating to non-medical emergency procedures. These should be posted in a place appropriate for inspection by staff members.

It is recommended that a smoke and burglar alarm system be installed in each facility.

Patient Fees and Records

Each facility should be morally obliged to have policies to accomodate low-income women. Specific financial arrangements should be made available to a minimum of 10% of the patient load.

There must be a contractual agreement between the woman and the facility outlining the payment plan and the collection policies. Collection policies must be in compliance with federal guidelines. The patient's record must not be released without the consent (preferably in writing) of the patient.

Confidentiality

Every woman has the right to expect her privacy will be respected and confidentiality of her records protected. Since most states do not have legislation protecting the confidentiality of medical records, care must be taken when making notation on her record (particularly counseling notes). In addition, if a member of the facility receives a subpoena for a woman's records, action must be taken to prohibit the release of

the records without the woman's consent.

Additional suggestions to protect confidentiality:

* Keep all doors locked in accordance with fire code except the door where the patients enter.

* Shred all waste paper that may have a patient's name or information before discarding.

* Lock all information with patient's names, including appointment books and daily logs each night.

* Keep any and all paper work with identifying names and numbers in desks - not unattended in full view of others in the clinic.

* Never disclose information about a patient that may be in the facility to a telephone caller; rather state that if that person is in the facility, she can

call the person back, and have them leave a number.

Minors

Minors should be served in the same manner as other women, keeping in mind possible restrictions upon hospital admissions without parental consent. If hospitals will not admit without parental consent, minors should be made aware that, in case of emergency, it may not be possible to maintain confidentiality.

Administrative Supervision

While direct professional supervision of physicians, nurses, and counselors is the responsibility of the senior professional in each area, the chief administrative officer responsible for the general supervision of clinic functions must assure that personnel policies and

procedures are formulated, distributed, and observed in an equitable manner.

In a professional organization such as an abortion service, this includes the arrangements for continuing training in the form of individual supervision, in-service education programs, and continuing education opportunities for all professional and paraprofessional staff members.

Individual agencies are responsible for knowledge of current local nurse practice acts. Agencies may not require nurses to practice outside the legal limits of local nurse practice acts.

Agencies are also responsible for knowledge of the current state of licensure and professional liability insurance for physicians engaged in medical practice within the facility or

those acting in its name.

REPORTING STANDARDS

The maintenance of complete and accurate records is important for quality patient care and meaningful review of services. Reporting of legally induced abortions to public agencies where required and to non-public agencies is essential for providing and improving maternal health and family planning services. Confidentiality of individual patient identity is essential and must be safeguarded in abortion reporting.

In order to provide a uniform basis for evaluation of abortion services, the National Abortion Federation requests each participating institution to provide the following data on a quarterly basis:

* the number of abortions performed;
* length of gestation;
* the percentage of patient followup

contact made within six weeks of the abortion;

* the number of deaths;

* the number of patients receiving one or more blood transfusion;

* perforation, known or suspected;

* the number of patients experiencing pelvic infection requiring hospitalization of at least 72 hours within two weeks of the abortion;

* the number of repeat abortion procedures because of retention of tissue within one month of the original procedure.

Data from individual institutions will be treated confidentially. The aggregate data will be analyzed and made available to participants. This data collection is distinguished from abortion reporting required by state or local

health departments.

REFERRAL STANDARDS

NAF member institutions which provide referral for abortion services are required to observe the following standards:

* Referrals must be limited to qualified physicians and services that maintain high standards. Those providing referral services must investigate and evaluate periodically the facilities to which they refer. Referral must be made to abortion facilities which have received an on-site inspection by either the referring agency or some other agency whose report is available.

* Whenever facilities are available, the woman should be offered an examination to establish the diagnosis and stage of pregnancy prior to referral.

* The state of health of the woman,

as well as the length of gestation, should be factors in determining the recommended choice(s) of the physician or service for referral.

* The facility providing the abortion service has a responsibility to report back, with the woman's consent, to the referring agency.

* No provider shall own or participate in a captive referral agency either proprietary or non-profit, that is not clearly identified to the consumer as affiliated with the provider service in question.

* Women must pay the fee for services to the agency rendering the service. If a referral agency offers counseling or aftercare services or charges a fee for referral, they must do so directly. Abortion facilities may not use referral

agencies to collect fees for abortion and related services. This does not include situations where contracts for third party payment for public-assistance patients are required for reimbursement.